

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-037436

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9481**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUD

AMENDED

FILED SEP 26 1963

VS 300 Rev. 4/59	DATE AMENDED	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	SHOULD READ	ITEM NO.
1							
2 9120							
3							
4 2							
5 2							
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7 1							
8 2							
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12 82-0							
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1. PLACE OF DEATH a. COUNTY Illinois		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY St. Clair	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri		c. CITY OR TOWN East St. Louis	
Length of stay in 1b		Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Infirmary		d. STREET ADDRESS (if outside, give location) 36 "A" Orr Weathers Homes	
Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Reside on Farm <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
3. NAME OF DECEASED (Type or print) First WILL Middle JOSH Last CLARK		4. DATE OF DEATH Month September Day 20 Year 1963	
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5/24/1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer		10b. KIND OF BUSINESS OR INDUSTRY Pipe Line Co.	11. BIRTHPLACE (City and state or country) Alexandria, La.
13a. FATHER'S NAME UNKNOWN		13b. MOTHER'S MAIDEN NAME MALINDA (UNKNOWN)	14. NAME OF HUSBAND OR WIFE NONE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. [REDACTED]	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 28 hrs	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerosis		Unknown	
DUE TO (c) 332x			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerotic Heart Disease		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour [REDACTED] a.m. [REDACTED] p.m.	Month, Day, Year [REDACTED]		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from 9-18-63 to 9-20-63 and last saw him alive on 9-18-63		Death occurred at 5:15 A m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE [Signature] (Degree or title) M.D.		22b. ADDRESS 2715 Union Place	22c. DATE SIGNED 9-20-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9/26/63	23c. NAME OF CEMETERY OR CREMATORY Local Cemetery	23d. LOCATION (City, town, or county) Alexandria, Louisiana
25. DATE RECD. BY LOCAL REG. SEP 23 1963		26. REGISTRAR'S SIGNATURE Paul Smith, M.D.	

USE BLACK INK OR TYPEWRITER RIBBON

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Marion C. Officer

Licensed Embalmer No. 5177
P. O. Address St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.